No. 94-725

Supreme Court, U.S.
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IN THE
Supreme Court of the United States
October Term, 1994

LIABILITY INVESTIGATIVE FUND EFFORT, INC.; LEONARD MORSE, M.D.; JUAN PENHOS, M.D.; WAYNE GLAZIER, M.D.; FRANCIS ROCKETT, M.D.; J. GORDON RICH, M.D.; AND JAMES BOYD, M.D.,
Petitioners,

v.

COMMONWEALTH OF MASSACHUSETTS, LINDA RUTHARDT, COMMISSIONER OF INSURANCE, COMMONWEALTH OF MASSACHUSETTS; AND MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT OF THE COMMONWEALTH OF MASSACHUSETTS.

BRIEF OF THE MASSACHUSETTS MEDICAL PROFESSIONAL INSURANCE ASSOCIATION IN OPPOSITION TO THE PETITION FOR WRIT OF CERTIORARI.

MICHAEL J. LACEK
PALMER & DODGE
One Beacon Street
Boston, Massachusetts 02108
(617) 573-0100

November 17, 1994

BATEMAN & SLADE, INC. BOSTON, MASSACHUSETTS

QUESTIONS PRESENTED

I. PROCEDURAL DUE PROCESS CLAIMS

A. *Deferred Premium Liability*

1. Did the Supreme Judicial Court of Massachusetts err in determining that the decision of the Massachusetts Legislature to delay the collection of certain medical malpractice rate increases embodied in Section 38 of Chapter 351 of the Massachusetts Acts of 1986 did not violate the petitioners' procedural due process rights?

2. Did the Supreme Judicial Court of Massachusetts err in determining that the petitioners did not have a protectible property interest in expressly provisional medical malpractice insurance rates?

B. *Deficit Recoupment*

1. Did the Supreme Judicial Court of Massachusetts err in determining the petitioners have no procedural due process claims under a deficit recoupment statute which had not been, and may never be, applied?

II. CONTRACTS CLAUSE CLAIM

A. *Deficit Recoupment*

1. Did the Supreme Judicial Court of Massachusetts err in determining that Chapter 333 of the Massachusetts Acts of 1980, which made prospective rate increases the sole means by which deficits of the Medical Malpractice Joint Underwriting Association (now "MMPIA") could be recouped, did not impair the obligations of any contract entered into prior to its enactment?

Table of Contents.

Questions presented	i
Table of authorities	iii
Constitutional and statutory provisions	2
Statement of the case	2
Reasons why the petition should be denied	6
I. Procedural due process	7
A. The Supreme Judicial Court correctly ruled that the deferred premium liability statute did not violate petitioners' due process rights	8
1. The decisions of the Massachusetts Legislature are not subject to procedural due process challenges	8
2. The petitioners do not have a protectible property interest in provisional insurance rates	9
B. The Supreme Judicial Court correctly held that the deficit recoupment statute has not operated to deprive petitioners of any property and, therefore, does not violate their right to procedural due process	11
II. Contracts clause	13
A. The Supreme Judicial Court correctly held that a prospective rate increase does not affect any pre-existing contracts and therefore could not violate the contracts clause	13
Conclusion	20

Table of Authorities Cited.

CASES.

Atkins v. Parker, 472 U.S. 115 (1985) 9

Bi-Metallic Inv. Co. v. State Bd. of Equalization, 239 U.S. 441 (1915) 9

Board of Regents v. Roth, 408 U.S. 564 (1972) 10, 11, 13

Employers' Commercial Union Ins. Co. v. Commissioner of Ins., 283 N.E.2d 849 (Mass. 1972) 11

Energy Reserves Group v. Kansas Power & Light, 459 U.S. 400 (1983) 18, 19

Fry Roofing Co. v. Wood, 344 U.S. 157 (1952) 12, 18

General Motors Corp. v. Romein, ___ U.S. ___, 112 S.Ct. 1105 (1992) 16, 19

Great N. Ry. v. Sunburst Oil and Ref. Co., 287 U.S. 358 (1932) 10, 13

Home Bldg. & Loan Ass'n v. Blaisdell, 290 U.S. 398 (1934) 13

Liability Investigative Fund Effort, Inc. v. Medical Malpractice Joint Underwriting Ass'n, 569 N.E.2d 797 (Mass. 1991) 3n, 5n

Liability Investigative Fund Effort, Inc. v. Medical Malpractice Professional Insurance Ass'n, 636 N.E.2d 1317 (Mass. 1994) *passim*

Local Div. 589, Amalgamated Transit Union v. Commonwealth, 666 F.2d 618 (1981), *cert. denied*, 457 U.S. 1117 (1982) 15, 16

Logan v. Zimmerman Brush Co., 455 U.S. 422 (1982) 9

Massachusetts Medical Society v. Commissioner of Ins., 520 N.E.2d 1288 (Mass. 1988) 5, 5n

Massachusetts Medical Society v. Commissioner of Inc., 537 N.E.2d 797 (Mass. 1989) 5n

TABLE OF AUTHORITIES CITED (CONT'D)

Medical Malpractice Joint Underwriting Association v. Commissioner of Ins., 478 N.E.2d 936 (Mass. 1985) 4, 5n, 8

Monks v. New Jersey, 398 U.S. 71 (1970) 12n

Murphy Nursing Home, Inc. v. Rate Setting Comm'n, 305 N.E.2d 837 (1973), *appeal dismissed*, 417 U.S. 962 (1974) 11

Ogden v. Saunders, 25 U.S. [12 Wheat.] 213 (1827) 16

Railroad Retirement Bd. v. Alton R.R., 295 U.S. 330 (1935) 12n

Rice v. City Cemetery, 349 U.S. 70 (1955) 7

Risk Management Foundation of Harvard Med. Institutions, Inc. v. Commissioner of Ins., 554 N.E.2d 843 (Mass. 1990) 3n, 5n, 12n, 16n, 19

Smith v. Illinois Bell Tel. Co., 270 U.S. 587 (1926) 12

U.S. Trust Co. v. New Jersey, 431 U.S. 1 (1977) 19n

STATUTES.

Massachusetts General Laws

c. 175A, § 5A 2, 4n, 6

Massachusetts Acts

1975, c. 362, § 6 *passim*
1980, c. 333 *passim*
1985, c. 671 5
1985, c. 671, § 1 8
1986, c. 37 5, 8
1986, c. 38 5

TABLE OF AUTHORITIES CITED (CONT'D)

Massachusetts Acts (cont'd)

1986, c. 351	8, 9
1986, c. 351, § 2	2, 5
1986, c. 351, § 15	2, 6
1986, c. 351, § 17	2, 6
1986, c. 351, § 18	2, 5
1986, c. 351, § 38	4, 9

OTHER AUTHORITY.

Massachusetts Senate Bill No. 1596	2, 4, 7n

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The respondent, the Massachusetts Medical Professional Insurance Association ("MMPIA"),[1] respectfully requests that

[1] The MMPIA was previously known as the Medical Malpractice Joint Underwriting Association of Massachusetts or the "JUA." In order to avoid confusion, this brief will refer to the association by its current acronym, as did the decision of the Supreme Judicial Court.

this Court deny the Petition for Writ of Certiorari, seeking review of the decision of the Supreme Judicial Court of Massachusetts in this case. That decision is reported at 636 N.E.2d 1317 (Mass. 1994), and reprinted in the appendix to the Petition.

CONSTITUTIONAL AND STATUTORY PROVISIONS.

In addition to the statutes and constitutional provisions set forth in the Petition, the MMPIA relies on Massachusetts General Laws, Chapter 175A, § 5A, Chapter 351 of the Massachusetts Acts of 1986, §§ 2, 15, 17, and 18, and Massachusetts Senate Bill No. 1596. Copies of these statutes and the proposed legislation are reprinted in the appendix hereto. (A1-A23).

STATEMENT OF THE CASE.

As has been true throughout this litigation, the petitioners generally ignore the undisputed facts that underlie this case and were relied upon by the Supreme Judicial Court, in a transparent attempt to manufacture issues of constitutional significance that were not decided, and did not need to be decided, by that court. In their Statement of the Case, the petitioners do not challenge the facts that the Supreme Judicial Court found to be controlling. Nor do they assert that there are additional facts that the Supreme Judicial Court neglected to consider that would compel a different conclusion on the legal issues that they seek to resurrect. Instead, the Petition poses a variety of abstract constitutional issues that are not raised or supported by the factual record below.

Rather than burden this Court with a point-by-point recitation of the inaccuracies and omissions in the petitioners' "Statement

of the Case," however, this brief generally will rely upon the concise statement of undisputed facts set forth in the Supreme Judicial Court's opinion.[2] (Pet. A2-A5). As is demonstrated in the argument that follows, when these undisputed facts are considered, the correctness of the Supreme Judicial Court's decision in denying the petitioners' constitutional claims is so obvious that it is understandable why the petitioners essentially ignored that decision in seeking relief from this Court. There are, moreover, several facts not addressed in the Supreme Judicial Court's decision that further compel the conclusion that this case presents no issue worthy of this Court's consideration.

This case involves a challenge to two Massachusetts statutes.[3] The first is the enabling legislation that established the MMPIA and provided for the recoupment of deficits incurred by it. St. 1975, c. 362, § 6, (the "Enabling Act") *as amended by* St. 1980, c. 333. (Pet. 2-3). Although several other states also established medical malpractice joint underwriting associations during the medical malpractice insurance crisis of the mid-1970's, the specific statutory mechanism for the recoupment of deficits at issue here is unique to Massachusetts. So too are the 1980 amendment to that statute and the terms and conditions of the insurance policies issued by the MMPIA prior to that amendment, which form the factual foundation for the petitioners' Contracts Clause claims.

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[2] To the extent that a more detailed historical background of the Massachusetts statutes at issue here would be helpful, the earlier decisions of the Supreme Judicial Court in *Risk Management Foundation of Harvard Med. Institutions, Inc.* v. *Commissioner of Ins.*, 554 N.E.2d 843 (Mass. 1990) and *Liability Investigative Fund Effort, Inc.* v. *Medical Malpractice Joint Underwriting Ass'n*, 569 N.E.2d 797 (Mass. 1991) are instructive.

[3] One of the more persistently frustrating factual mischaracterizations engaged in by the petitioners is their insistence that these two statutes are "really" one in the same, *see*, Petition, (p. 4, n.2), when it is perfectly clear that they are not. *See* decision below (Pet. A8, n.5).

Moreover, as the Supreme Judicial Court noted, although the MMPIA initiated a request for a prospective rate increase to recoup deficits in 1987, no such rate increase has ever been established, much less assessed against the petitioners. (Pet. A4, A12). In fact, the financial position of the MMPIA has now improved to the point that it no longer needs to recoup any deficits and would have dismissed the pending administrative proceedings, but for the refusal of another party to that proceeding to agree to a dismissal during the pendency of this lawsuit. In any event, the MMPIA is not actively pursuing deficit recoupment and has sponsored legislation to convert the MMPIA into a mutual company that would not have any authority to recoup deficits. *See* Massachusetts Senate Bill No. 1596, A17-A23. Thus, the petitioners' challenge to the deficit recoupment statute asserts injuries that have never occurred and are not likely to occur.

The second statute challenge by the petitioners, the so-called "deferred premium liability" statute, St. 1986, c. 351, § 38, (Pet. 3, A17-A20), was also enacted to address circumstances unique to Massachusetts medical malpractice ratemaking. In substance, that statute permitted the deferred collection of medical malpractice rate increases for the 1983, 1984, and 1985 policy years. Those rate increases arose out of a successful appeal to the Supreme Judicial Court, decided in 1985, that overturned the Commissioner's initial decision establishing the rates for the 1983 policy year. *Medical Malpractice Joint Underwriting Association of Mass.* v. *Commissioner of Ins.*, 478 N.E.2d 936 (Mass. 1985).[4] The collection of the increases for 1983 and

[4]The medical malpractice ratemaking statute, Massachusetts General Laws chapter 175A, § 5A, provides in pertinent part: "Any person or company aggrieved by any action, order, finding or decision of the commissioner under this section may, within twenty days from the filing of such memorandum thereof in his office, file a complaint in the supreme judicial court for the county of Suffolk for a review of such action, order, finding or decizion." (A4). The 1983 rates were reviewed under this statute, and the Commissioner was ordered by the court to correct various aspects of his decision and to set the 1983 rates accordingly.

the establishment of the rates for 1984 and 1985 were delayed when the Legislature temporarily froze the premiums that could be charged by the MMPIA at the level of the provisional 1983 rates overturned by the Supreme Judicial Court's 1985 decision. St. 1985, c. 671 *as amended by* St. 1986, c. 37. The 1986 deferred premium liability statute authorized the MMPIA to collect these rate increases, as well as the increase for 1985, over a five-year period commencing in 1987, in order to avoid the undue economic burden of a one-time charge upon the affected physicians. St. 1986, c. § 38. (Pet. A17-A20). That same statute required that the fees paid to physicians by medical service corporations (*e.g.* Blue Cross/Blue Shield of Massachusetts) and by governmental and workers' compensation payors be increased to compensate physicians for these increases in medical malpractice insurance rates. St. 1986, c. 351, §§ 2, 18. (A7, A10-A16). *See Massachusetts Medical Society* v. *Commissioner of Ins.*, 520 N.E.2d 1288, 1297-98 (Mass. 1988). The last of the deferred premium liability was billed and collected more than three years ago.[5] During the period that the MMPIA collected the deferred premium liability, physicians also received the increased fees required by Sections

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Medical Malpractice Joint Underwriting Association v. *Commissioner of Ins.*, 478 N.E.2d 936 (Mass. 1985). Subsequent decisions of the Supreme Judicial Court addressing the deferred premium liability include *Massachusetts Medical Society* v. *Commissioner of Ins.*, 520 N.E.2d 1288, 1291-92 (Mass. 1988); *Massachusetts Medical Society* v. *Commissioner of Ins.*, 537 N.E.2d 797 (Mass. 1989); and an earlier decision in this case, *Liability Investigative Fund Effort, Inc.* v. *Medical Malpractice Joint Underwriting, Ass'n.*, 569 N.E.2d 797 (Mass 1991). The Supreme Judicial Court also has previously addressed issues arising out of the administrative proceeding concerning deficit recoupment in *Risk Management Foundation of Harvard Med. Institutions, Inc.* v. *Commissioner of Ins.*, 554 N.E.2d 843 (Mass. 1990).

[5] The MMPIA did not collect the fifth and final year of deferred premium liability, because more mature ratemaking data which became available in 1989 and 1990 indicated that the additional premium would not be necessary to cover the actuarially determined losses and expenses for the deferred premium liability rate years.

2 and 18 of the statute to compensate them for the increased malpractice rates.

Furthermore, to avoid the delays that occurred in implementing the 1983, 1984, and 1985 rate increases, the Legislature also amended the ratemaking statute applicable to medical malpractice rates. Those amendments provided (a) that rate requests by the MMPIA be filed more than a year in advance of their effective date; (b) that the decision of the Commissioner with respect to such filings be made at least four months prior to the effective date of the rates; and (c) that interim rates equal to the rates recommended by one of the parties to the hearing be charged in the event that the rates are not finally fixed in accordance with the statutory schedule. Mass. G.L. c. 175A, § 5A, *as amended by* St. 1986, c. 351, §§ 15 and 17. (A1-A6, A8-A10). Thus, the deferred premium liability statute was a legislative response to unique factual circumstances that were limited to Massachusetts medical malpractice ratemaking during the specific years in question and that will not reoccur under the revised statutory system.

REASONS WHY THE PETITION SHOULD BE DENIED.

Because the issues in this case involve unique factual circumstances peculiar to Massachusetts medical malpractice ratemaking and, consequently, will not arise again even in Massachusetts, a decision by this Court would be of purely academic interest, if any, to anyone other than the parties involved. Accordingly, the petitioners have not shown and cannot establish that the issues raised in this case are of sufficient public importance to warrant consideration by this Court. As this Court has stated:

> A federal question raised by a petitioner may be of "substance" in the sense that, abstractly considered, it may present an intellectually interesting and solid problem. But this Court does not sit to satisfy a scholarly interest in such issues. Nor does it sit for the benefit of the particular litigants . . . "Special and important reasons" imply a reach to a problem beyond the academic or the episodic.

Rice v. *City Cemetery*, 349 U.S. 70, 74 (1955). (Citations omitted).

The Supreme Judicial Court was thoroughly familiar with both the statutes governing the establishment of medical malpractice insurance rates for the MMPIA and the complex legislative and procedural history that underlies the issues in the case. *See* n.4 *supra* (referring to the five Supreme Judicial Court decisions that underlie the present decision). When that history is considered, it is clear that the Supreme Judicial Court correctly identified and decided the limited constitutional issues that the petitioners were entitled to raise. Consequently, there is no issue that warrants further review by this Court.

I. PROCEDURAL DUE PROCESS.

The procedural due process issue framed by the petitioners treats the two statutes they challenge as though they were identical by asking "whether the textual and applied statutory power of a state agency retroactively to recoup medical malpractice insurance premiums violates the petitioners' right to procedural due process." (Pet. 6). As noted above, however, the two statutes the petitioners are challenging function differently and, as the Supreme Judicial Court recognized, must

be analyzed separately. (Pet. A4, A8). After evaluating the petitioners' claims with respect to each statute, the Supreme Judicial Court correctly ruled that neither St. 1986, c. 351, the deferred premium liability statute (Pet. A17-A20), nor St. 1975, c. 362, § 6, *as amended by* St. 1980, c. 333, the deficit recoupment statute (Pet. 2-3), violated the petitioners' procedural due process guarantees in the Massachusetts or United States Constitutions. (Pet. A8-A13).

A. *The Supreme Judicial Court Correctly Ruled That The Deferred Premium Liability Statute Did Not Violate Petitioners' Due Process Rights.*

1. The decisions of the Massachusetts Legislature are not subject to procedural due process challenges.

The Supreme Judicial Court correctly rejected the petitioners' arguments that delay in collecting rate increases imposed by the deferred premium statute violated their procedural due process rights. St. 1986, c. 351. (Pet. A17-A20). The 1986 Deferred Premium Liability Statute permitted the MMPIA to collect the difference between (1) the provisional malpractice premium rates billed to physicians and hospitals for the 1983, 1984 and 1985 rate years and (2) the final, higher rates approved after a successful appeal and a remand to the Insurance Commissioner. The provisional rates that were billed were established by a decision of the Commissioner issued on May 18, 1984, which was later overturned by the Supreme Judicial Court in *Medical Malpractice Joint Underwriting Association* v. *Commissioner of Ins.*, 478 N.E.2d 936 (Mass. 1985). The Legislature subsequently froze the premium rates for policies issued on or after July 1, 1984 at the rates initially established by the Commissioner on May 18, 1984. *See* St. 1985, c. 671, § 1, *as amended* by St. 1986, c. 37.

After the Commissioner of Insurance established revised premium rates for the 1983 and 1984 policy years in his decision on remand from the Supreme Judicial Court, the Legislature passed the deferred premium statute in 1986. That statute allowed the MMPIA to collect the difference between the provisional premiums already received and the new higher rates but required that the collection be deferred and collected over five years. St. 1986, c. 351, § 38. (Pet. 3, A17-A20). As the Supreme Judicial Court held, the delay in establishing and collecting the premium increases challenged by the petitioners was expressly imposed by the Legislature in these statutes. (Pet. A9). Consistent with the decisions of this Court, the Supreme Judicial Court reasoned that the petitioners could not maintain a *procedural* due process challenge to these legislative decisions. (Pet. A9, citing *Logan* v. *Zimmerman Brush Co.*, 455 U.S. 422, 433 (1982) (legislative process itself affords "all the process that is due")) *See also Atkins* v. *Parker*, 472 U.S. 115, 127-130 (1985) (no right to individual notice of statutory changes in benefits); *Bi-Metallic Inv. Co.* v. *State Bd. of Equalization*, 239 U.S. 441, 445-446 (1915) (state legislative acts are not generally subject to procedural due process challenges).

2. The petitioners do not have a protectible property interest in provisional insurance rates.

As a second ground for denying the petitioners' due process challenge to the deferred premium liability statute, the Supreme Judicial Court properly concluded that the petitioners had no legitimate property interest in the provisional malpractice premiums they were originally charged. (Pet. A9-A10). The Supreme Judicial Court found that each of the policies issued in the years governed by St. 1986, c. 351 declared on its face

that the malpractice premium rates being charged were provisional. (Pet. A9). The court concluded that because the original rates were expressly subject to change once the final rates were established, the petitioners did not have a protected property interest in the original rates. (Pet. A10).

The Supreme Judicial Court's conclusion that petitioners have no legitimate property interest in expressly provisional insurance rates is consistent with the standard established by this Court in *Board of Regents* v. *Roth*, 408 U.S. 564 (1972). For petitioners to demonstrate that they have a property interest in preserving the malpractice premiums they were originally charged:

> [They] must have more than an abstract need or desire for it. [They] must have more than a unilateral expectation of it. [They] must, instead, have a legitimate claim of entitlement to it.

Id. at 577.

The petitioners were on notice from the time the MMPIA was established in 1975 that the rates established by the Commissioner were subject to review by the Supreme Judicial Court. (A3-A4). Thus, the petitioners had statutory notice and, through the declarations on the face of the policy, actual notice that the rates were subject to change. When such expressly provisional rates are later revised, procedural due process is not violated. *Great N. Ry.* v. *Sunburst Oil and Ref. Co.*, 287 U.S. 358, 361-362 (1932) (commission's decision to change provisional shipping rates did not violate right of procedural due process).

Accordingly, consistent with the principles enunciated by this Court and with its own decisions, the Supreme Judicial Court properly determined that the petitioners had no protec-

tible property interest in the provisional rates the MMPIA charged in 1983, 1984 and 1985. *See Murphy Nursing Home, Inc.* v. *Rate Setting Comm'n*, 305 N.E.2d 837, 841 (Mass. 1973) *appeal dismissed*, 417 U.S. 962 (1974), ("[t]he Constitution of the United States interposes no barrier to retroactive redetermination of provisional or tentative rates"); *Employers' Commercial Union Ins. Co.* v. *Commissioner of Ins.*, 283 N.E.2d 849, 853 (Mass. 1972) (because insurance rates were expressly subject to change, they did not constitute property). For all of these reasons, the Supreme Judicial Court correctly concluded that the deferred premium liability statute did not violate the petitioners' due process rights.

B. *The Supreme Judicial Court Correctly Held That The Deficit Recoupment Statute Has Not Operated to Deprive Petitioners of Any Property And, Therefore, Does Not Violate Their Right to Procedural Due Process.*

There is a fundamental flaw in petitioners' argument that the "textual and applied statutory power" that allows the MMPIA to recoup deficits violates petitioners' procedural due process rights (Pet. 6-7): the petitioners have never been required to pay any additional malpractice premiums pursuant to the deficit recoupment statute. Thus they have never been *deprived* of any property within the meaning of the Fourteenth Amendment. *See Board of Regents* v. *Roth, supra*, 408 U.S. at 569 ("The requirements of procedural due process apply only to the deprivation of interests encompassed by the Fourteenth Amendment's protection of liberty and property.").

The petitioners attempt to obfuscate their failure to meet this prerequisite by mischaracterizing the deferred premium liability rate increase as an exercise of the deficit recoupment power. (Pet. 4). The Supreme Judicial Court properly disre-

garded this transparent sleight of hand designed to create a constitutional issue and held, based upon the undisputed facts in the record, that the Commissioner of Insurance has not ordered any recoupment nor established any rate increase since the MMPIA filed is request in 1987 to recoup deficits for the years 1975 through 1982. (Pet. A4, A12). That finding would not be disturbed, even if this Court were to grant certiorari in this case. *Fry Roofing Co.* v. *Wood*, 344 U.S. 157, 159-60 (1952) (state court findings are not subject to review if there is any evidence in the record to support them). As the Supreme Judicial Court properly determined, that finding renders entirely inapposite *Smith* v. *Illinois Bell Tel. Co.*, 270 U.S. 587, 591 (1926), and related cases holding that delay in acting upon a requested rate increase may result in confiscation of property in violation of the requesting company's right to procedural due process. (Pet. A11).[6] The petitioners' contention that their constitutional rights have been harmed by something that has not yet happened does not merit the attention of this Court.[7]

Moreover, even if a prospective rate increase had been established and assessed pursuant to the deficit recoupment statute, for much the same reasons already discussed in connection with the deferred premium liability statute, the petitioners would be

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[6] The petitioners' citation of this Court's decision in *Railroad Retirement Bd.* v. *Alton R.R.*, 295 U.S. 330 (1935) suggests that they may be attempting to articulate a substantive due process claim. As the Supreme Judicial Court noted, however, the petitioners had stipulated to the dismissal of their takings claims prior to its decision. (Pet. A. 11, n.8). Therefore, they cannot pursue this claim upon this writ. *See Monks* v. *New Jersey*, 398 U.S. 71 (1970) (writ of certiorari dismissed where state courts had no opportunity to pass on the issue raised). It is also noteworthy in this regard that the Supreme Judicial Court has already held, in a prior decision, that the statutory recoupment authority challenged here is a valid exercise of the Legislature's police powers. *Risk Management Foundation of Harvard Med. Institutions, Inc.* v. *Commissioner of Ins.*, 554 N.E.2d 843, 847-48 (Mass. 1990).

[7] As noted above, the Court should also bear in mind that the MMPIA is currently sponsoring legislation that would eliminate the deficit recoupment authority. *See* Senate Bill 1596, A17-A23.

unable to establish that they were deprived of any protectible property interest. The deficit recoupment statute is part of the original enabling legislation that established the MMPIA "to provide medical malpractice insurance on a self-supporting basis." St. 1975, c. 362, § 6. In order to be self-sustaining, the MMPIA was given the authority pursuant to Paragraph 7 of § 6 of the Enabling Act, to recoup any deficit for any year by either an assessment, a prospective rate increase, or both, and the petitioners took their policies subject to this deficit recoupment power. *See Home Bldg. & Loan Ass'n* v. *Blaisdell*, 290 U.S. 398, 429-30 (1934). "[T]he laws which subsist at the time and place of the making of a contract, and where it is to be performed, enter into and form a part of it, as if they were expressly referred to or incorporated in its terms."). (Citatations omitted).

Given the statutory authority to recoup deficits, which predated any interest that the petitioners may have in the medical malpractice rates charged by the MMPIA, they cannot and do not have a constitutionally protected property interest in preserving the level of malpractice premiums they originally paid. *See Board of Regents* v. *Roth*, 408 U.S. 564, 577-78 (1972); *Great N. Ry.* v. *Sunburst Oil & Ref. Co.*, 287 U.S. 358, 361-62 (1932). The failure to demonstrate such an interest is fatal to their procedural due process claim, and the Supreme Judicial Court properly rejected it.

II. CONTRACTS CLAUSE.

A. *The Supreme Judicial Court Correctly Held That a Prospective Rate Increase Does Not Affect Any Pre-Existing Contracts And Therefore Could Not Violate The Contracts Clause.*

The petitioners' Contracts Clause argument also misstates the issue that was decided by the Supreme Judicial Court. The questions is not "whether an unconstitutional impairment of contract occurs when a subsequently enacted statute is used

to substantially alter the obligation of an existing contract" (Pet. 9); rather, the question is whether the *prospective* rate increase being challenged here affects existing contracts at all. The Supreme Judicial Court correctly found that it does not.

The statute that the petitioners challenge under the Contracts Clause is St. 1980, c. 333, which amended the MMPIA's Enabling Act to eliminate the assessment mechanism for recoupment of deficits, leaving a prospective rate increase as the only recoupment method. See Pet. 11-12, stating their "core" claim. As originally enacted, the Enabling Act read:

> Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect by [an assessment upon the policyholders, or] a rate increase applicable prospectively[, or both]; provided, however, that in no event shall a deficit incurred by the association be charged, directly or indirectly, to any person other than the insured under a policy of medical malpractice insurance; and provided, further, that for purposes of this sentence, when deficits sustained on account of physician or hospital malpractice coverage are being recouped, the term 'policyholders' shall mean all those licensed physicians or hospitals insured under a policy of medical malpractice insurance, whether obtained through the joint underwriting association or not."

St. 1975, c. 362, § 6. The bracketed language was eliminated by St. 1980, c. 333, which left in place "a rate increase applicable prospectively" as the sole method for the MMPIA to recoup deficits.

Prior to the enactment of St. 1980, c. 333, the MMPIA's policies contained an endorsement that put its policyholders on notice that they were subject to assessments to recoup deficits. For example, the 1977 policy stated:

> The policy is assessable pursuant to Section 6 of Chapter 362 of the Acts of 1975. Any deficit sustained by the Medical Malpractice Joint Underwriting Association in any one year shall be recouped by an assessment upon all medical malpractice insurance policyholders, whether insured through the Joint Underwriting Association or otherwise. It is agreed, therefore, that in addition to any other premium due under this policy, an assessment shall be payable if and when a deficit is declared by the Board of Directors of said Association.

The petitioners contend that the MMPIA, by the use of this language, committed itself to recouping deficits *solely* by means of assessments and *not* via a prospective rate increase. Thus, the petitioners argue, the MMPIA's attempt to recoup deficits by the prospective rate increase method that has always been authorized by its Enabling Act is an impairment of their pre-1980 insurance policies.[8]

The Supreme Judicial Court correctly rejected this argument on the straightforward basis that "a rate increase applicable prospectively" cannot violate the Contracts Clause, which "applies only to laws with retrospective, not prospective, effect." (Pet. A7); (quoting *Local Div. 589, Amalgamated Transit*

[8] In fact, the petitioners go further and argue that even though the MMPIA's policies subsequent to the enactment of St. 1980, c. 333 do not contain the assessment endorsement, the MMPIA is nonetheless bound to recoup deficits from those policy years solely by means of assessments because the MMPIA did not expressly terminate the endorsement. (Pet. 11).

Union v. *Commonwealth*, 666 F.2d 618, 637 (1st Cir. 1981), *cert. denied*, 457 U.S. 1117 (1982) (citing *Ogden* v. *Saunders*, 25 U.S. [12 Wheat.] 213 (1827)). In reaching this conclusion, the Supreme Judicial Court determined that "[the petitioners] simply fail to distinguished between actions taken by the MMPIA under its existing contracts with policyholders and actions taken by the Legislature and the MMPIA regarding the terms of the MMPIA's future contracts." (Pet. A7). The court noted that under the statute, a prospective rate increase to recoup deficits applies to all medical malpractice insureds regardless of whether they have ever had a policy with the MMPIA, so that "it is clear that the application of that increase cannot be part of past MMPIA contracts."[9] (Pet. A8). Furthermore, "[the petitioners] will not themselves be subject to any eventual rate increases under the deficit recoupment statute if they are not insured under malpractice policies in Massachusetts at the time such increases are imposed." *Id.*

The petitioners attempt to duck the Supreme Judicial Court's fatal blow to their Contracts Clause theory by seeking refuge in the general statement set forth in *General Motors Corp.* v. *Romein*, ___ U.S. ___, 112 S.Ct. 1105, 1109-10 (1992), that a contract clause analysis

> has three components: whether there is a contractual relationship, whether a change in law impairs that contractual relationship, and whether the impairment is substantial. Normally, the first two are unproblematic, and we need address only the third.

[9] The constitutionality of that aspect of the MMPIA's Enabling Act was upheld by the Massachusetts Supreme Judicial Court in *Risk Management Foundation* v. *Commissioner of Ins.*, 554 N.E.2d 843 (Mass. 1990), and is not before this Court.

The petitioners' conclusory assertions to the contrary notwithstanding, the Massachusetts Supreme Judicial Court found the second component, whether there is an impairment at all, to be not only problematic but dispositive.

Any rate increase to recoup deficits for prior years will apply to the petitioners if, and only if, they are medical malpractice policyholders in Massachusetts when, and only when, such a prospective rate increase is approved by the Commissioner and goes into effect. The petitioners' liability for such an increase is entirely independent of their earlier contracts with the MMPIA. Accordingly, the petitioners' argument that they whould be shielded from this liability by the fortuity that they were policyholders at a time when policyholders were *also* subject to recoupment by assessment was properly addressed by the Supreme Judicial Court and does not merit consideration by this Court.

Because the Supreme Judicial Court determined that St. 1980, c. 333 did not impair petitioners' contracts, it did not reach the principal arguments pressed by the Petition that the nonexistent impairment was substantial. However, even if this Court were to consider that issue, the undisputed facts compel the conclusion that any impairment that the petitioners might attempt to prove was both insubstantial and justified by the statute's important public purpose.

The change in recoupment method from assessment to prospective rate increase did not substantially alter the expectations of the parties to these policies. All physicians and hospitals in Massachusetts were at all times on notice of their potential liability for deficits sustained by the MMPIA. From its inception, the MMPIA was empowered to recoup deficits, first by means of an assessment, a prospective rate increase, or both, and then by a rate increase alone. Even if the policyholders had an expectation that the MMPIA would only use the assessment power, a prospective rate increase does not substantially

alter that expectation. *See Energy Reserves Group* v. *Kansas Power & Light*, 459 U.S. 400, 411 (1983) ("state regulation that restricts a party to gains it reasonably expected from the contract does not necessarily constitute a substantial impairment"). Additionally, because the MMPIA is not only heavily regulated, but state created and mandated, the petitioners were on notice that the Legislature might amend the recoupment power and thereby alter their expectations. *See Energy Reserves*, 459 U.S. at 411 (when a person engages in "an enterprise already regulated in the particular to which he now objects, he [does so] subject to further legislation upon the same topic.").

In any event, there is no evidence that the petitioners' liability would increase under the prospective rate increase method of deficit recoupment as opposed to assessments. The petitioners admit as much, arguing only that they "did not bargain to be members of a *potentially and/or actually different, and possibly even smaller* pool of ratepayers who might exist when the MMPIA finally got around to levying a prospective rate increase." (Pet. 15) (emphasis added). As the Supreme Judicial Court held, that wholly unsupported and speculative concern does not constitute evidence of any actual harm to the petitioners arising out of the amendment (Pet. A12); a finding which would not be disturbed by this Court. *Fry Roofing Co.*, 344 U.S. at 159-160.

Moreover, even if some impairment of the petitioners' contract could be hypothesized, it would pale in comparison to the important public purpose served by the statute being challenged. As the Supreme Judicial Court has previously held:

> Clearly, c. 333 bears a substantial relation to the public health. The [MMPIA] was created to guarantee that medical malpractice insurance would remain available so as to ensure that doctors continue to

> practice and that hospitals continue to operate in the Commonwealth. In order to maintain the viability of the [MMPIA], the Legislature could reasonably turn to doctors and hospitals in the event of a deficit. These groups, it should be noted, benefit from the existence of the [MMPIA], in that [MMPIA] insurance was and is available to them, and in that the [MMPIA's] presence helps to maintain the smooth operation of the medical care marketplace.

Risk Management Foundation v. *Commissioner of Ins.*, 554 N.E.2d 843, 848 (Mass. 1990). Any impairment of contract, if one could be found in this case, "must be accommodated to the inherent police power of the State to safeguard the vital interests of its people." *Energy Reserve Group*, 459 U.S. at 410.[10] However, since the Supreme Judicial Court correctly decided that there was no impairment of contract here, there is no basis for the petitioners to impose on this Court to address the issue. *See General Motors*, 112 S.Ct. at 1110.

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[10] The petitioners argue that the MMPIA should be subject to the "heightened standard of review" courts apply where a law impairs the state's own contracts (Pet. 12-13). In those cases, a court's usual "deference to a legislative assessment of reasonableness and necessity is not appropriate." *U.S. Trust Co.* v. *New Jersey*, 431 U.S. 1, 26 (1977). The MMPIA is a self-supporting entity that does not rely on state funding; the state's self interest, which is cited as the basis for imposing a heightened standard, is not present here. In any event, even under the "heightened" standard urged by the petitioners, there was sufficient justification for any impairment that might be attributed to St. 1980, c. 333.

CONCLUSION.

For all of these reasons, the Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

MICHAEL J. LACEK
PALMER & DODGE
One Beacon Street
Boston, Massachusetts 02108
(617) 573-0100

Counsel for Respondent

November 17, 1994

APPENDIX
TABLE OF CONTENTS

Massachusetts General Laws, c. 175A, § 5A	A1
Massachusetts Acts of 1986, c. 351, § 2	A7
Massachusetts Acts of 1986, c. 351, § 15	A8
Massachusetts Acts of 1986, c. 351, § 17	A9
Massachusetts Acts of 1986, c. 351, § 18	A10
Massachusetts Senate Bill No. 1596	A17

C. 175A

§ 5A. Medical Malpractice Insurance.

The commissioner shall, annually on or before March first with respect to each twelve month period commencing on the following July first, after due hearing and investigation, fix and establish fair and reasonable classification of risks and adequate, just, reasonable and nondiscriminatory premium charges on claims made and occurrence basis to be used and charged by companies in connection with the issue or execution of medical malpractice insurance during the twelve month period commencing July first in said calendar year or any part of said twelve month period. In connection with any such hearing, the advisory filing of the Joint Underwriting Association established pursuant to section six of chapter three hundred sixty-two of the acts of nineteen hundred and seventy-five and any insurance company shall be filed with the commissioner on or before April first of the calendar year preceding the calendar year in which the decision is to be issued, advisory filings of any other parties to the hearing shall be filed on or before May fifteenth of such calendar year, and the hearing shall be commenced on or before July first of such calendar year; provided, however, that the advisory filing for said association for the twelve month period beginning July first, nineteen hundred and eighty-seven shall be filed with the commissioner on or before September first, nineteen hundred and eighty-six and other advisory filings for said period shall be filed on or before October first, nineteen hundred and eighty-six. The commissioner shall consider whether it is advisable to and establish limited practice classification of risks within each classification of risk established pursuant to this section. In fixing and establishing premium charges in accordance with

the provisions of this section, the commissioner shall prorate equally all charges to the insured according to actual calendar days of coverage. The effective dates of procurement or cancellation of insurance from insurance companies shall determine the cost to the insured for each coverage on an equal per diem basis established for the calendar year cost of insurance policies. The commissioner shall, on or before said date, sign memoranda of the classifications and premium charges fixed and established by him in such form as he may prescribe and file the same in his office and cause a duly certified copy of such classifications and schedule of premium charges forthwith to be transmitted to each company authorized to issue such policies. During said calendar year, the classification and premium charges fixed and established by the commissioner from such policies may be used as a maximum charge by a company issuing such policies, however such premiums below the premiums established by the commissioner shall be uniform for all such classifications throughout the commonwealth. Such deviation shall be filed with the commissioner and he shall allow such deviation only if the commissioner finds that the premium charges the insurer desires to use are adequate, just, reasonable and nondiscriminatory and will not be used by the insurer as a means of attracting only such risks as are regarded as presenting less hazard of loss than others in the same classification. Every application for permission to so deviate shall be filed with the commissioner subsequent to and within thirty days of his having filed in his office the memorandum aforesaid and shall specify the basis thereof and shall be accompanied by the data upon which the applicant relies. The commissioner shall then set the time and the place for a hearing on such applications at which the applicant may be heard and shall give the applicant not less then ten days written notice thereof. The time so established for the hearing shall not be later than thirty days after receipt by the commissioner of the application.

If the commissioner finds that the deviation is justified and the resulting premium charges satisfy the requirements of this section, he shall issue an order permitting the deviation to be used by the applicant for the ensuing calendar year beginning January first.

In fixing and establishing the charges, as provided in this section, the commissioner shall take into account investment income and potential income from unearned premiums, loss reserves and all cash flows.

The commissioner may make, and at any time, alter or amend, reasonable rules and regulations to facilitate the operation of this section and enforce the application of the classifications and premium charges fixed and established by him, and to govern hearings and investigations under this section. The commissioner may at any time require any company to file with him such data, statistics, schedules or information as he may deem proper or necessary to enable him to fix and establish or secure and maintain fair and reasonable classifications of risks and adequate, just, reasonable and nondiscriminatory premium charges for such policies. Every company selling medical malpractice insurance coverage in the commonwealth shall file with the commissioner complete financial records showing the amount of profit or loss made on every classification of medical malpractice insurance during the previous year, and shall also file records showing profits from investment income including investment income on net realized capital gains and loss reserves and unearned premiums. The commissioner may issue such orders as he finds proper, expedient or necessary to enforce and administer the provisions of this section, to secure compliance with any rules or regulations made thereunder, and to enforce coherence to the classifications and premium charges fixed and established by him. The supreme judicial court for the county of Suffolk shall have jurisdiction upon the complaints of the commissioner and upon a summary

hearing, to enforce all lawful orders of the commissioner. Memoranda of all actions, orders, findings and decisions of the commissioner shall be signed by him and filed in his office as public records open to public inspection. A copy of all such memoranda shall be sent to the Special Commission on Medical Malpractice established pursuant to chapter three hundred and sixty-two of the acts of nineteen hundred and seventy-five.

Any person or company aggrieved by any action, order, finding or decision of the commissioner under this section may, within twenty days from the filing of such memorandum thereof in his office, file a complaint in the supreme judicial court for the county of Suffolk for a review of such action, order, finding or decision. An order of notice returnable not later than seven days from the filing of such complaint shall forthwith issue and be served upon the commissioner. Within ten days after the return of said order of notice, the complaint shall be assigned for a speedy and summary hearing on the merits. The action, order, finding or decision of the commissioner shall remain in full force and effect pending the final decision of the court unless the court or a justice thereof after notice to the commissioner shall by a special order otherwise direct. The court shall have jurisdiction to modify, amend, annul, reverse or affirm such action, order, finding or decision, shall review all questions of fact and of law involved therein and may make any appropriate judgment. The decision of the court shall be final and conclusive on the parties. The court may make such order as to costs as it deems equitable. The court shall make such rules or orders as it deems proper, governing proceedings under this section to secure prompt and speedy hearings and to expedite final decisions thereon.

If, for any reason, classifications of risks and premium charges fixed and established as aforesaid on or before March first in any year for the ensuing twelve month period are not effective for said year, the commissioner shall establish the

classifications of risks and premium charges requested by one of the interested parties for the ensuing year as an interim rate until classifications of risks and premium charges for said ensuing twelve month period are finally fixed and established. Classifications of risks and premium charges when finally fixed and established for said ensuing calendar year shall become effective as of July first of said twelve month period, and all premium charges affected by any change thereby made which have been paid or incurred prior to the time when such charges are finally fixed and established shall be adjusted in accordance with such change, as of said July first.

Every mutual company issuing medical malpractice insurance policies shall constitute such policies as a separate class of business for the purpose of paying dividends. Any dividends on such policies shall be declared on the profits of the company from said class of business.

Insurance companies shall, at the option of the insured, accept payment of medical malpractice insurance premiums in installments under plans, rates and charges approved by the commissioner, after such notice as shall be prescribed by the commissioner and after public hearing thereof, provided, however, that each insurance company shall offer at least one installment payment plan for each policy which either gives the insured the option to pay the annual premium in a minimum of six monthly installments or gives the insured the option to pay the annual premium in four quarterly installments.

Effective sixty days after the inception of a medical malpractice insurance contract no notice of intention to terminate the contract or, if the contract is a renewal, no notice of intention not to renew the contract shall be effective unless the insurer at least ninety days prior to the effective date of such cancellation or the end of the contract period, as the case may be, mails or delivers to the insured at the address shown on the policy such notice of cancellation or intention not to renew

except where the cancellation is for nonpayment of premium, or where the insured has lost his license to practice medicine, or if the insured is a hospital, no longer possesses a valid operating certificate.

For the purposes of this section, a medical malpractice insurance contract shall mean in insurance contract covering liability arising out of the practice of medicine by a duly licensed physician or the operation of a duly certified hospital with respect to the treatment of patients, including all acts of its agents and employees. (1975, 362, § 4; 1977, 613; 1986, 351, §§ 15-17, approved July 23, 1986; by § 41, effective October 1, 1986.)

Chapter 351. An Act Relative to Medical Malpractice.

Be it enacted, etc., as follows:

SECTION 2. Section 32 of said chapter 6A, as so appearing, is hereby amended by inserting after the fourth paragraph the following four paragraphs: —

In determining rates to be paid to providers of health care services, by governmental units, and by insurers under chapter one hundred and fifty-two, the commission shall adjust such rates effective July first, nineteen hundred and eighty-seven and each July first thereafter through and including July first, nineteen hundred and ninety-one, for changes in medical malpractice insurance premiums fixed and established pursuant to section five A of chapter one hundred and seventy-five A for such providers of health care services.

The total adjustments shall be sufficient to generate, over a twelve-month period, additional payments to physicians or dentists equal to the total dollar increase in medical malpractice insurance premium charges over the charges which were in effect prior to the decision to fix and establish new premium charges, multiplied by the following fraction: (a) The numerator shall be the percent of total revenues for physicians, or dentists, which are paid by governmental units as to which the rates of payment are fixed and established by the rate setting commission pursuant hereto, plus the percent of total revenues for physicians, or dentists, which are paid by insurers under chapter one hundred and fifty-two; and (b) The denominator shall

be one hundred percent minus the percent of total revenues for physicians, or dentists, paid by medical service corporations under policies providing supplemental coverage to health insurance under Title XVIII of the Social Security Act. The percent amounts specified for the numerators and denominators above, and the amount of the total dollar increase in medical malpractice insurance premium charges shall be the amounts determined by the commissioner of insurance pursuant to section five B of chapter one hundred and seventy-five A. In the event that medical malpractice insurance premium charges decrease, negative adjustments shall be made pursuant to the same formula.

The adjustments shall take effect with the next routinely-scheduled change in payments or rates following the change in medical malpractice insurance premiums. The commission shall make available a list of the adjustments, by procedure or procedure code, that have been made pursuant to this paragraph.

Whenever the premiums or rates of worker's compensation insurance are subject to regulation of the commissioner of insurance, the commissioner shall allow such insurer to include within its premiums, rates or subscription charges such adjusted payments, effective as of the date that such adjusted payments were first implemented.

ACTS, 1986. — Chap. 351.

SECTION 15. The first paragraph of section 5A of chapter 175A of the General Laws, as appearing in the 1984 Official Edition, is hereby amended by striking out the first sentence and inserting in place thereof the following three sentences: — The commissioner shall, annually on or before March first with respect to each twelve month period commencing on the

following July first, after due hearing and investigation, fix and establish fair and reasonable classification of risks and adequate, just, reasonable and nondiscriminatory premium charges on claims made and occurrence basis to be used and charged by companies in connection with the issue or execution of medical malpractice insurance during the twelve month period commencing July first in said calendar year or any part of said twelve month period. In connection with any such hearing, the advisory filing of the Joint Underwriting Association established pursuant to section six of chapter three hundred sixty-two of the acts of nineteen hundred and seventy-five and any insurance company shall be filed with the commissioner on or before April first of the calendar year preceding the calendar year in which the decision is to be issued, advisory filings of any other parties to the hearing shall be filed on or before May fifteenth of such calendar year, and the hearing shall be commenced on or before July first of such calendar year; provided, however, that the advisory filing for said association for the twelve month period beginning July first, nineteen hundred and eighty-seven shall be filed with the commissioner on or before September first, nineteen hundred and eighty-six and other advisory filings for said period shall be filed on or before October first, nineteen hundred and eighty-six. The commissioner shall consider whether it is advisable to and establish limited practice classification of risks within each classification of risk established pursuant to this section.

SECTION 17. Said section 5A of said chapter 175A, as so appearing, is hereby further amended by striking out the sixth paragraph and inserting in place thereof the following paragraph: —

If, for any reason, classifications of risks and premium charges fixed and established as aforesaid on or before March

first in any year for the ensuing twelve month period are not effective for said year, the commissioner shall establish the classifications of risks and premium charges requested by one of the interested parties for the ensuing year as an interim rate until classifications of risks and premium charges for said ensuing twelve month period are finally fixed and established. Classifications of risks and premium charges when finally fixed and established for said ensuing calendar year shall become effective as of July first of said twelve month period, and all premium charges affected by any change thereby made which have been paid or incurred prior to the time when such charges are finally fixed and established shall be adjusted in accordance with such change, as of said July first.

SECTION 18. Said chapter 175A is hereby further amended by inserting after section 5A the following section: —

Section 5B. On or before September first of the calendar year preceding the date by which the commissioner shall fix and establish classifications of risks and premium charges pursuant to section five A of chapter one hundred and seventy-five A, each medical service corporation shall file with the commissioner of insurance such data as will show the percentage of total revenues for physicians and for dentists in Massachusetts, which is attributable to payments by it which are subject to the limitations on charges and collections in section seven of chapter one hundred and seventy-six B, and the percentage of such total revenues which is attributable to payments by it under policies providing supplemental coverage to health insurance provided under Title XVIII of the Social Security Act. Any interested party, including, without limitation, organizations of physicians or dentists and agencies of the commonwealth or of the United States, may file, within the same time period, data relating to the total revenues for physicians or

dentists in Massachusetts and the percentage share thereof paid by:

(a) medical service corporations for services which are subject to the limitations on charges and collections in section seven of chapter one hundred and seventy-six B;

(b) governmental units as to which the rates of payment for professional services to physicians or dentists are fixed and established by the rate setting commission pursuant to section thirty-two of chapter six A;

(c) insurers under chapter one hundred and fifty-two;

(d) health insurance under Title XVIII of the Social Security Act;

(e) medical service corporations under policies providing supplemental coverage to health insurance provided under Title XVIII of the Social Security Act; and

(f) all other payors, including, without limitation, medical service corporations to the extent their payments are not included in items (a) to (e), inclusive.

The commissioner of insurance may require any insurer, health maintenance organization or other payor making payments to physicians or dentists in the commonwealth for medical or dental services, to file such data as will show that payor's total payments to physicians or dentists in the commonwealth during such prior time period as the commissioner of insurance shall specify, and such other or further data as may be necessary to carry out the provisions of this section.

No later than November first, the commissioner shall hold a hearing to determine, based on the data filed by medical service corporations or any other party, or on other data or reasonable estimates available to him and introduced into the record in the said hearing, the percentage share of total revenues for physicians and the percentage share of total revenues for dentists, in Massachusetts, paid by the following:

(a) medical service corporations for services which are subject to the limitations on charges and collections in section seven of chapter one hundred and seventy-six B;

(b) governmental units as to which the rates of payment for professional services to physicians or dentists are fixed and established by the rate setting commission pursuant to section thirty-two of chapter six A;

(c) insurers under chapter one hundred and fifty-two;

(d) health insurance under Title XVIII of the Social Security Act;

(e) medical service corporations under policies providing supplemental coverage to health insurance under Title XVIII of the Social Security Act; and

(f) all other payors, including, without limitation, medical service corporations to the extent their payments are not included in items (a) to (e), inclusive. Said determination shall be made no later than March first of the succeeding calendar year.

Any interested party, which has filed data relating to the said percentages of total revenues for physicians and dentists and the medical malpractice analysis bureau, shall be entitled to participate in the hearing thereon, to present oral and written evidence, to examine and cross-examine witnesses, to review all information and materials filed with or relied on by the commissioner of insurance, and to submit briefs or position papers to any determination by the commissioner of insurance.

Any interested party which has participated in the said hearing and which is aggrieved by any action, order, finding or decision of the commissioner of insurance under this section may, within twenty days from the filing of his decision thereof in his office, file a complaint in the supreme judicial court for the county of

Suffolk for a review of such action, order, finding or decision, and serve a copy thereof upon the commissioner of insurance and the attorney general. Within twenty days after the service of said complaint, the complaint shall be assigned for a speedy and summary hearing on the merits. The action, order, finding or decision of the commissioner of insurance shall remain in full force and effect pending the final decision of the court. The court shall have jurisdiction to modify, amend, annul, reverse or affirm such action, order, finding or decision, but such action, order, finding or decision shall not be modified, amended, annulled or reversed, unless the court finds that the commissioner of insurance erred as a matter of law, or that the decision was unsupported by any evidence in the record, with every reasonable inference in support of the decision made therefrom. The decision of the court shall be final and conclusive on the parties. The court shall make such rules or orders as it deems proper governing proceedings under this section to secure prompt and speedy hearings and to expedite final decisions thereon. In the event that the court modifies, amends, annuls or reverses such action, order, finding or decision, the decision of the court shall be implemented by the commissioner in the next hearing, commenced pursuant to this section, following said decision.

Payment made by any medical service corporation relating to services subject to the limitations on charges and collections in section seven of chapter one hundred and seventy-six B which are rendered by participating physicians or dentists covered by policies of medical malpractice insurance shall be adjusted for changes in medical malpractice premium charges fixed and established pursuant to section five A of chapter one hundred and seventy-five A. The medical service corporations payment shall be the amount of the total malpractice adjustment for that procedure code in addition to the amount paid to the physician for that procedure.

The total adjustments shall be sufficient to generate, over a twelve-month period, additional payments to physicians or dentists equal to the total dollar increase in medical malpractice insurance premium charges over the charges which were in effect prior to the decision to fix and establish new premium charges, multiplied by the following fraction: (a) The numerator shall be the percent of total revenues for physicians, or dentists, which the medical service corporation's payments for services subject to the limitations of section seven of chapter one hundred and seventy-six B constitute, plus one-half of the percent of total revenues for physicians, or dentists, paid by health insurance under Title XVIII of the Social Security Act; and (b) The denominator shall be one hundred percent minus the percent of total revenues for physicians, or dentists, paid by the medical service corporation under policies providing supplemental coverage to health insurance under Title XVIII of the Social Security Act. In the event that medical malpractice insurance premium charges decrease, negative adjustments shall be made pursuant to the same formula.

Any participating physician or participating dentist, when filing a request for payment based on a procedure code with said corporation, shall be allowed to include the dollar amount of the total adjustment allocated for that procedure code; provided, however, that said dollar amount shall not be separately stated. Upon submission of such dollar amount by the physician, the medical service corporation shall include all of that dollar amount in the amount paid to the physician for that procedure code. No change in medical malpractice insurance premium charges shall be approved by the commissioner of insurance until he has determined the percentage shares of total revenues for physicians or dentists paid by the medical service corporations and others as provided above. The adjustment to payments by the medical service corporation shall take effect with the next regularly scheduled change in payments

following the change in medical malpractice insurance premiums. The medical service corporation shall make available to participating physicians and dentists a list of the adjustments by the procedure code that have been made prior to the next regularly scheduled change in payments. The medical service corporation shall also provide said list to the division of insurance, which shall make available such list upon request.

In determining the total adjustment that shall be made to participating physicians and participating dentists for the twelve month period beginning July first, nineteen hundred and eighty-seven, the commissioner shall include in the calculation of total adjustment increases in medical malpractice insurance premium charges made for the twelve month period beginning July first, nineteen hundred and eighty-six; provided, further, that in calculating the total adjustment to be made by the medical service corporation for the twelve month period beginning July first, nineteen hundred and eighty-seven, the commissioner shall allow a credit for the aggregate amount of physician reimbursements made pursuant to increases in medical malpractice premiums by the Joint Underwriters Association made by said medical service corporation effective July first, nineteen hundred and eighty-six.

Whenever the premiums, rates or subscription charges of a medical service corporation are subject to regulation by the commissioner of insurance, the commissioner of insurance shall allow such corporation to include within its premiums, rates or subscription charges such adjusted payments to participating physicians and participating dentists, effective as of the date that such adjusted payments were first implemented. Nothing in this paragraph or the preceding paragraph shall be construed to affect the responsibilities and authority of the commissioner of insurance under chapter one hundred and ninety-nine of the acts of nineteen hundred and eighty-four. This paragraph shall not apply to payments made for charges

regulated by chapter three hundred and ten of the acts of nineteen hundred and eighty-four.

The provisions of this section shall terminate upon the completion of the rate period ending June thirtieth, nineteen hundred and ninety-two.

The commissioner shall determine the methodology pursuant to which each medical service corporation shall allocate the total adjustments among procedure codes in order that payments to physicians and dentists are apportioned among the risk classifications established by the commissioner under section five A. The methodology will provide for application of the adjustments to usual charge levels for each physician or dentist and to customary charge levels, in each instance separately stated by procedure code for purpose of this section the commissioner shall make this determination on a biannual basis provided however that upon the motion of any party at any future hearing under this section. The commissioner shall review the methodology previously approved by him and approve such changes as may be necessary in order that the allocation methodology apportion such payments in accordance with this paragraph.

The provisions of this section shall terminate upon the completion of the rate period ending June thirtieth, nineteen hundred and ninety-two.

SENATE . . . . . No. 1596

By Mr. Berry, a petition (accompanied by bill, Senate, No. 1596) of Frederick E. Berry for legislation to convert the Medical Professional Insurance Association into the Medical Professional Mutual Insurance Company. Insurance.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Ninety-Four.

AN ACT CONVERTING THE MEDICAL PROFESSIONAL INSURANCE ASSOCIATION INTO THE MEDICAL PROFESSIONAL MUTUAL INSURANCE COMPANY.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. The commissioner of insurance is hereby authorized and directed to approve the conversion of the Association and the Association is hereby converted into a mutual insurance company to be known as the Medical Professional Mutual Insurance Company, which shall succeed to and assume all of the assets and liabilities of the Association. All rights, interests and properties of the Association shall, without any further act or deed, be the property of the resulting mutual company, and the resulting mutual company shall remain bound by all obligations of the Association under policies of

insurance issued by it. No contracts, claims, suits or other rights of or against the Association shall be affected by this conversion.

SECTION 2. Section 13 of Chapter 362 of the Acts of 1975, as most recently amended by Section 11 of Chapter 65 of the Acts 1992, is hereby further amended by striking out the second sentence of said section and inserting in place thereof the following sentence: "Section six of this Act shall terminate upon the conversion of the joint underwriting association into the Medical Professional Mutual Insurance Company."

SECTION 3. The Medical Professional Mutual Insurance Company shall be authorized to transact any and all kinds of insurance, as the commissioner shall approve. Except as provided herein, or in its articles of organization or bylaws, such company shall have all powers conferred upon a mutual insurance company incorporated in the commonwealth and shall be subject to all provisions of the General Laws which are now or may in the future be applicable to such companies.

SECTION 4. The Medical Professional Mutual Insurance Company shall be governed until the annual meeting of the company held in 1997 by the Board of Directors of the Association as constituted on the date of the conversion of the Association into the company, subject to filling vacancies as provided in the company's bylaws. Thereafter, the company shall be governed by a board of not less than eleven directors, which may be divided into classes pursuant to section 77 of Chapter 175 of the General Laws, and shall, notwithstanding any other provision of law, be selected in the manner set forth in the company's bylaws.

SECTION 5. Notwithstanding any other provision of any general or special law, the Medical Professional Mutual Insurance Company shall:

(a) not establish a guarantee capital, nor shall it be subject to any of the provisions of chapter one hundred and seventy-five of the General Laws providing for voting rights by shareholders in any such guarantee capital, provided that nothing herein shall preclude the company from establishing a guarantee fund in accordance with the General Laws;

(b) not be subject to the provision of sections seventy-three, ninety A, ninety C, ninety-two, ninety-three A and ninety-three B of said chapter one hundred and seventy-five, insofar as they relate to subscriptions for insurance or securing initial applications for insurance;

(c) not be subject to the provisions of the first paragraph of sections fifty-eight and fifty-nine of said chapter one hundred and seventy-five; and

(d) be authorized to issue nonassessable polices.

SECTION 6. Upon approval of the commissioner, the Medical Professional Mutual Insurance Company may for any purposes, including, but not limited to the fixing of separate percentages of dividends under section eighty of chapter one hundred and seventy-five, consider the business of each category of health care provider as a separate line of business; provided further, however, that the doctor of dental science category of insured shall continue to be treated as a separate line of business to the extent required by Chapter 92 of the Acts of 1991.

SECTION 7. Section 5A of Chapter 175A of the General Laws is hereby repealed. The Medical Professional Mutual Insurance Company shall remain subject to the remaining provisions of said Chapter 175A to the extent that those provisions

otherwise apply to a mutual insurance company incorporated in the commonwealth.

SECTION 8. (a) As used in this section, the following words shall have the following meaning:

"Medical malpractice insurance," insurance coverage against the legal liability of the insured for loss, damage or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional service by any health care provider.

"Medical malpractice insurer," an insurer authorized to write and engaged in writing medical malpractice insurance within the commonwealth on a direct basis.

"Net direct premiums," gross direct premiums written on personal injury liability insurance written pursuant to the provisions of chapter one hundred and seventy-five of the General Laws, including the liability component of multiple peril package policies as computed by the commissioner less all premiums and dividends credited or returned to policyholders or the unused or unabsorbed portions of premium deposits.

"Health care provider," any doctor of medicine, osteopathy, optometry, dental science, podiatry, chiropractic, or a registered nurse licensed under the provisions of chapter one hundred and twelve of the General Laws, an intern, fellow, or medical officer licensed under section nine of said chapter one hundred and twelve, or a licensed hospital, clinic, or nursing home, and its agents and employees.

"Medical Malpractice Analysis Bureau, the Medical Malpractice Analysis Bureau established in the Division of Insurance pursuant to Section 8I of Chapter 26 of the General Laws.

(b) All medical malpractice insurers shall accept the assignment of risks by the Medical Malpractice Analysis Bureau on a non-discriminatory basis as provided in this section. Any licensed health care provider upon proof that the health care

provider has made a reasonable effort to obtain insurance and has been unable to obtain it shall be entitled to apply through the Medical Malpractice Analysis Bureau for such coverage. Such application may be made on behalf of an applicant by a broker or agent authorized by the applicant. If the Bureau determines that the applicant meets the underwriting standards of the Bureau and there is no unpaid, uncontested premium due from the applicant for prior insurance as shown by the insured having failed to make written objection to premium charges within the thirty days after billing, it shall make an assignment of the risk to a medical malpractice insurer. The assignments of risk required by this section shall be allocated among medical malpractice insurers during any one calendar year in the proportion that the net direct premiums of each such insurer written during the preceding calendar year, excluding that portion of premiums attributable to the assignment of risks pursuant to this section written by such insurer during the preceding calendar year, bears to the aggregate net direct premiums written in the commonwealth by all medical malpractice insurers during the preceding calendar year. Each insurer's allocation of assigned risks pursuant to this section shall be determined annually on the basis of such net direct premiums written during the preceding calendar year as are reported in the annual statements and other reports filed by the insurer with the commissioner.

(c) Each company receiving assignments of risk pursuant to this section shall, as a condition of its authority to transact insurance within the commonwealth, cause to be issued to such approved applicant, upon receipt of the full annual premium, a policy of insurance for a term of one year. Following the one year policy term, any eligible applicant may apply through the Medical Malpractice Analysis Bureau for reassignment in the same manner as set forth above.

(d) The commissioner may make, and at any time alter or amend, reasonable rules and regulations to facilitate the operation of this section and to enforce the assignment of risks made by the Medical Malpractice Analysis Bureau pursuant to this section, including, but not limited to, regulations regarding the rates and the terms and conditions of the policies issued to such assigned risks.

SECTION 9. (a) Section 8I of Chapter 26 of the General Laws, as enacted by Section 4 of Chapter 351 of the Acts of 1986, is hereby amended by striking from the first sentence of the first paragraph the words "the medical malpractice joint underwriting association" and by inserting in place thereof the words "a medical malpractice insurer."

(b) Said section 8I of said Chapter is hereby further amended by inserting the following sentence after the first sentence in the first paragraph:

"The medical malpractice analysis bureau shall also oversee the assignment of health care provider risks, who are unable to obtain medical malpractice insurance, among the medical malpractice insurers writing in the commonwealth."

(c) Said Section 8I of said Chapter 26 is hereby further amended by striking from the first sentence of the second paragraph the words "the medical malpractice joint underwriting association" and inserting in place thereof the words "medical malpractice insurers."

(d) Said Section 8I of said Chapter 26 is hereby further amended by inserting the following sentence after the second sentence of the second paragraph: "The assessment shall be allocated among all medical malpractice insurers in the proportion that the net direct premiums of each such insurer written during the preceding calendar year, excluding that portion of premiums attributable to the assignment of risks pursuant to this section written by such insurer during the preceding calen-

dar year, bears to the aggregate net direct premiums written by all medical malpractice insurers during the preceding calendar year."

(e) Said Section 8I of said Chapter 26 is hereby further amended by striking from the third sentence of the second paragraph the words "joint underwriting association" and by inserting in place thereof the words "medical malpractice insurers."

(f) Said Section 8I of said Chapter 26 is hereby further amended by adding the following paragraph after the second paragraph:

"As used in this section the following words shall have the following meanings:

"Medical malpractice insurance," insurance coverage against the legal liability of the insured for loss, damage or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional service by any health care provider.

"Medical malpractice insurer," an insurer authorized to write and engaged in writing medical malpractice insurance within the commonwealth on a direct basis.

"Net direct premiums," gross direct premiums written on personal injury liability insurance written pursuant to the provisions of chapter one hundred and seventy-five of the General Laws including the liability component of multiple peril package policies as computed by the commissioner less all premiums and dividends credited or returned to policyholders or the unused or unabsorbed portions of premium deposits.

"Health care provider," any doctor of medicine, osteopathy, optometry, dental science, podiatry, chiropractic, or a registered nurse licensed under the provisions of chapter one hundred and twelve of the General Laws, an intern, fellow, or medical officer licenses under section nine of said chapter one hundred and twelve, or a licensed hospital, clinic, or nursing home, and its agents and employees."